Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RIO GRANDE REGIONAL HOSPITAL
C/O HOLLAWAY & GUMBERT
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098

Respondent Name

TEXAS MUNICIPAL LEAGUE
INTERGOVERNMENTAL RISK

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-05-3212-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "IC failed to pay claim per TWCC Rules 134.401(c)(4)(A)(i) and (B)(ii) of Acute Care Inpatient Hospital Fee Guideline; IC failed to pay implants at cost plus 10%, failed to pay CAT Scan at fair and reasonable."

Amount in Dispute: $3,122.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has paid per the ACIHFG and based upon the documentation provided by the Requestor. Full documentation of the cost of implantables (items that are truly implantables) is required. Carrier has paid $6,822.36. Requestor has failed to establish it is entitled to a total of $32,366.32."

Response Submitted by: City of Hidalgo, FOL, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2004 through January 8, 2004	Inpatient Services	$3,122.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes

filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on January 6, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 11, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated February 26, 2004

   - 510-Payment determined.
   - M-No MAR.
   - F-Fee Guideline MAR Reduction.
   - 304-Submit Supply House Invoice for additional.

   Explanation of Benefits dated May 7, 2004
   - 940-Re-evaluation no additional payment recomm.
   - 175-Services have been previously paid.
   - 510-Payment determined.
   - O-Denial after Reconsideration – terminated.
   - 506-Re-evaluated bill, payment adjusted.
   - S-Supplemental Payment.

Findings

1. The Division finds inconsistencies in the submitted documentation of the claimant's date of injury. On the initial position summaries and DWC-60 form, both parties noted the date of injury as December 15, 2003. On the requestor's supplemental position summary, bills and EOBs the date of injury is listed as July 23, 1998. A review of Division records does not find a date of injury of December 15, 2003 for the claimant's social security number. Therefore, the Division concludes that the claimant's date of injury is July 23, 1998.
2. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
3. 28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted medical bill and itemized statement, indicate that the requestor billed for two (2) inpatient surgical days; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
4. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."
5. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore 2 multiplied by $1,118.00 = $2,236.00.

   A review of the submitted EOBs supports reimbursement of $2,236.00 for inpatient surgical services; therefore, the requestor was paid in accordance with 28 Texas Administrative Code §134.401(c)(1) and (c)(3)(B).
6. 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in addition to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursements apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
7. 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

   The requestor states in the position summary that "IC failed to pay implants at cost plus 10%." A review of the submitted medical bill indicates that the requestor billed $14,679.00 for revenue code 278 – supply and implants. The requestor submitted the Cost Invoice, computer printout of implants, and itemized statement that support the implants cost at $1,324.96. Per 28 Texas Administrative Code §134.401(c)(4), to determine the MAR, reimbursement is the cost plus 10%. Therefore, $1,324.96 + 10% = $1,457.45. The submitted

EOBs indicate that the respondent paid $1457.46; therefore, the requestor was paid appropriately for the implantables and additional reimbursement cannot be recommended.

8. 28 Texas Administrative Code §134.401(c)(4)(B), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619); (ii) Computerized Axial Tomography (CAT scans) (revenue codes 350-352, 359); (iii) Hyperbaric oxygen (revenue code 413); (iv) Blood (revenue codes 380-399); and (v) Air ambulance (revenue code 545)."

   The Division finds that the requestor billed $1727.50 for revenue code 352 - CT scan/body.
9. Per 28 Texas Administrative Code §134.401(c)(4)(B), revenue code 352 will be reimbursed at a fair and reasonable rate.
10. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
11. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
12. 28 Texas Administrative Code §133.307(g)(3)(B), requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(g)(3)(B).
13. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
    - The requestor's position statement asserts that "failed to pay CAT Scan at fair and reasonable."
    - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
    - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
    - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
    - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

    The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		01/13/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.